CENTERS FO	ENTERS FOR MEDICARE & MEDICAID SERVICES					OM	IB NO. 0938-0391
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	LETED
		155704	B. WIN			11/15	/2012
NAME OF	PROVIDER OR SUPPLIE	R	-	STREET.	ADDRESS, CITY, STATE, ZIP CODE	•	
TWIND OF	I NO VIDEN ON BOLLER		505 N MAIN ST				
WALDR	ON HEALTH AND F	REHAB CENTER		WALDF	RON, IN 46182		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, i	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000							
	Complaints IN IN00119144.  Complaint IN0 - Federal/State the allegations F309.  Complaint IN0 - Federal/State the allegations F314.  Unrelated defi Survey dates: November 14  Facility Number Provider Numl Aim Number: Survey Team: Mary Jane G.  Census Bed T SNF/NF: 67 Total: 67	& 15, 2012 er: 000423 ber: 155704 100290450 Fischer RN	F00	00	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because is required by the provisions of federal and state law.	the se it	
	Census Payor Medicare: 20	<b>3</b> .					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000423

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Medicaid: 45

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/10/2012 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155704		00	COMPI 11/15	
	ROVIDER OR SUPPLIER  ON HEALTH AND REHAB CENTER	505 N N	ADDRESS, CITY, STATE, ZIP COM MAIN ST RON, IN 46182	DE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	Other: 2 Total: 67				
	Sample: 5				
	These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.				
	Quality review 11/21/12 by Suzanne Williams, RN				

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Event ID: EP5G11

Facility ID: 000423

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155704	B. WIN			11/15/	2012
			B. WIIV	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
WALDEC		ELIAD CENTED			MAIN ST		
WALDRO	N HEALTH AND R	ENAB CENTER		WALDR	RON, IN 46182		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCE	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	=	DATE
F0241	483.15(a)					•	
SS=D	DIGNITY AND RE	ESPECT OF					
	INDIVIDUALITY						
		promote care for residents					
		n an environment that					
		ances each resident's					
	dignity and respect or her individuality	ct in full recognition of his					
	-	rvation, record review	F02	41	Resident B was assessed by		12/14/2012
		the facility failed to			nursing and found to have no		
		nity of a resident, which			adverse effects from alleged		
		opriate remarks by a			deficient practice. Certified Nurses		
	• •	•			Aide #6 was immediately taken from	1	
		s Aide [employee #6]			the floor, interviewed, and		
	for 1 resident in	n a sample of 5.			re-educated prior to working the		
	[Resident "B"].				remainder of her shift following the		
					alleged incident.		
	Findings includ	e:			All residents have the		
	3				potential to be effected by the		
	The record for	Resident "B" was			alleged deficient practice.		
					Facility staff have been in-serviced		
		-14-12 at 1:10 p.m.			on appropriate interactions with		
	•	uded, but were not			residents.		
	limited, to hype	ertension, arthritis,			3. Facility staff have been		
	neuropathy, dia	abetes mellitus and			inserviced on appropriate		
	peripheral vaso	cular disease. These			interactions with residents, resident		
	diagnoses rema	ained current at the			rights, and the Abuse Prevention,		
	time of the reco				Intervention, Investigation, and		
	51 475 1000				Crime Reporting policy.		
	Dovious of the r	esident's Minimum			4. Any allegations of		
					inappropriate interactions will be		
		ssment, dated 04-12-12			reported to the Administrator or the	2	
	indicated the re				Director of Nursing and addressed		
	cognitively impa	aired, and required			immediately with the suspected		
	extensive assis	stance with transfer and			staff member. Allegations will be		
	bed mobility.				reviewed by the Quality Assessment		
					and Assurance Committee for		
	Paview of the r	esident's current plan			recommendations for ongoing		
					quality improvement.		
	or care, origina	lly dated 05-16-11,					

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Event ID: EP5G11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURV	'EY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPLETED	)
		155704	B. WIN			11/15/2012	2
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	· ·		505 N N	MAIN ST		
	ON HEALTH AND F	REHAB CENTER		WALDR	RON, IN 46182		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	MPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
		esident was at "high					
		ate to severe pain					
	experience(s)						
	, , ,	europathy, cellulitis and					
	•	<sic> cord impairment."</sic>					
	"Pain location	- back, legs."					
	•	current plan of care,					
		d 05-16-11, indicated					
		ad "self care deficit with					
	-	elated to weakness and					
	neuropathy." A	An intervention to this					
	plan of care in	cluded the use of a					
	mechanical lift	for all transfers.					
	_	w on 11-15-12 at 10:25					
		ent agreed to a skin					
		nd during observation					
		the Director of Nurses					
		lurses Aide employee					
		the resident onto the					
		and transferred the					
	resident to bed	i.					
	_	servation the resident					
		ertified Nurse Aide, "be					
		legs, they hurt." Once					
		as lowered to the bed,					
		urse Aide started to					
	•	sident when again the					
	resident instru	cted the Certified					
	Nurses Aide "c	oh be careful with my					
	legs." The Cer	rtified Nurse Aide					
	responded to t	he resident "Are you					
	being a t [ter	minology for a bowel					

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Event ID: EP5G11

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPL	ETED
		155704	B. WING		11/15/	2012
)	an outline on outline			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEI	K	505 N	MAIN ST		
	ON HEALTH AND F			RON, IN 46182		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX TAG	· ·	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEI (CIENCI)		DATE
	excrement]?"					
	The meet of a maked	id not necessary. The				
	The resident did not respond. The Certified Nurse Aide then turned the					
		left side and again the				
		nented to the Certified				
	· ·	which the Certified				
	Nurse Aide res	sponded, "you turkey."				
		f Nurses instructed the				
		she would be needed				
	to transfer the	resident from bed and				
	back into the v	vheelchair after a body				
	assessment ha	ad been completed.				
	The employee	indicated she would go				
	to lunch "now"	and then be available.				
	Once the resid	lent was positioned				
	comfortably in	bed, the Certified				
	Nurse Aide sta	ated, "I'll be back later,				
	honey."					
	During this obs	servation, the Director				
		·				
	Spouse, were i	in attenuance.				
	There was no	intervention by the				
	2000000.					
	Durina intervie	w on 11-15-12 at 10:55				
	. •					
	l '					
		-				
	of Nurses as was pouse, were in the service of Nurses as was no Director of Nurses occurrence.  During interview a.m., the Director she heard the Certified Nurses	vell as the resident's				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPL	ETED
		155704	B. WIN			11/15/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	L.		1	MAIN ST		
WALDRO	N HEALTH AND R	EHAB CENTER			ON, IN 46182		
(V4) ID	CLIMMA DAY C	TATEMENT OF DEPLOYENCIES	1		,		(V5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION DATE
TAG		LSC IDENTIFTING INFORMATION)		TAG	BETTELENET,		DATE
	with her."						
	During the exit	conference on					
	11-15-12 at 2:0	00 p.m., the Director of					
	Nurses indicate	ed the Certified Nurse					
	Aide was "talke	ed to" at the time of the					
	incident, and se						
	inologorit, and st	one to idition.					
	   When further in	nterviewed, the Director					
		·					
		ated she interviewed					
		on the hallway in					
		fied Nurse Aide					
	"usually worked						
	complaints abo	out any behavior issues					
	with the Certific	ed Nurse Aide. The					
	Director of Nur	ses indicated she					
		ployee to return to					
	work after lunc	• •					
	Work after faile	111.					
	Davious of the	ampleyee's timeserd					
		employee's timecard					
		Certified Nurses Aide					
		t 10:36 a.m. and the					
	"clocked in" at	11:08 a.m., less than					
	15 minutes afte	er the interview with the					
	Director of Nur	ses at 10:55 a.m.					
	3.1-3(t)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE S	(3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLE			ETED	
		155704	B. WIN			11/15/	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				MAIN ST		
WALDRO	N HEALTH AND R	EHAB CENTER			RON, IN 46182		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0282 SS=D	483.20(k)(3)(ii) SERVICES BY QUENTICES BY QUENTICES BY QUENTICES BY QUENTICES Provided in the services provided in the services provided in the services provided in the services and interview, sensure the resident of the services physician order regard to eliminate the services of the services included in the services of the service	the facility failed to dent's plan of care and rs were implemented in nation and positioning 5 sampled residents. and "B"].  The:  The resident "A" was 1-14-12 at 10:35 a.m. uded, but were not bral palsy, chronic istory of abdominal eus, diabetes mellitus cobladder. These ained current at the ord review.  The hospitalization in the record indicated do hospitalization	F02	TAG 82	1. Residents A and B were assessed by nursing and found have no adverse effects from alleged deficient practice. The plans of care in regards to elimination and positioning have been reviewed and revised as needed.2. All residents have to potential to be effected by the alleged deficient practice. 3. Facility staff have been reinserviced on following physician's orders and the resident's plan of care.4. The Interdisciplinary Team will mat CNA worksheets, Care Plans a resident position during Interdisciplinary Team Rounds ensure that each resident is positioned and repositioned according to his or her care plated according to his or he	eir ve the ch and s to an. ne	12/14/2012
	-	ecal impaction," and primary/secondary			Committee for six months.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLI	
		155704	B. WIN			11/15/	2012
NAME OF P	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP CODE		
WALDRO	ON HEALTH AND F	PEHAR CENTER		505 N M	MAIN ST NON, IN 46182		
				<u> </u>	1011, 111 40102	Ī	Q15)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	diagnoses - fe	cal impaction, and					
	paralytic ileus."						
	,	pararytic fieds.					
	Review of a "M	lajor Internal Medicine"					
	report, dated 0	6-26-12, indicated the					
	resident had a	recent assessment of					
		fficile - plan: Continue					
	_	ent] bowel pattern					
	carefully."						
		recent Hospital					
	_	struction Report," dated					
		ated "please medics ninister the MiraLax [a					
		aide in elimination] one					
		ne initiation of tube					
	•	ht." "Additional					
	_	ents" included "Ideally					
		nave 2 - 4 stools per					
		nt] misses any day					
	-	then give 2 doses of					
		ay. If the following day					
	[resident] has	, ,					
	physician."	<u>-</u>					
	Review of the						
		record for November					
		I the physician order,					
		2, for MiraLax 255 gm					
	[grams]/14 oz. [ounces] give 17 gram						
	per gtube [gastrostomy feeding tube]						
		of water prn a day					
		nen give a dose of					
		0 a.m. Resident goal is					
	2 - 4 soft stools	s per day."					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU	RVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLET	ED
		155704	B. WIN			11/15/20	)12
NAME OF B	DOLUDED OD GLIDDLIEF		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	C		505 N N	MAIN ST		
WALDRO	ON HEALTH AND R	REHAB CENTER		WALDR	RON, IN 46182		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE C	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
	dated 05-30-12 white blood cel abdominal com severe fecal im "Indication: Abdistention - Imp severe fecal im The resident's originally dated as of 11-01-12 for constipation [diagnoses] ch cerebral palsy "goal" to this pl "Resident will h movements QI Interventions to included "Bowe needed], Repo [abdominal] dis [nausea/vomiti [Medical Docto juice prn, Reco elimination dat Dulcolax supp. ordered, and R medication] as	current plan of care, d 10-20-08 and current, indicated "Potential h/gastric distress - Dx. ronic constipation, health issues." The lan of care included have 2 - 4 bowel D [every day]." this plan of care el sounds prn [as lot loose stools, abd. stention], N/V ng] etc, Notify MD or] as needed, Prune ord elimination, Monitor a, MiraLax QD and prn, [suppository] as Rezyst [a probiotic ordered."					
	since the date	'BM [bowel eport for the resident of re-admission esident had one bowel					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLI	
		155704	B. WIN	G		11/15/2	2012
NAME OF I	PROVIDER OR SUPPLIEI	₹			ADDRESS, CITY, STATE, ZIP CODE		
WALDD.		DELLAR OFNITER			MAIN ST		
WALDRO	ON HEALTH AND F	REHAB CENTER		WALDR	ON, IN 46182		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	TE	COMPLETION DATE
1710		11-04-12, 11-06-12,		1710			DATE
		9-12, 11-11-12, and					
	11-13-12, and						
		11-05-12 from 4:13					
		6-12 at 8:00 p.m. when					
		indicated the resident					
		wel movement, no					
		ent from 11-09-12 at					
	10:33 a.m., un	til 11-11-12 at 4:30					
	a.m. and no bo	owel movement from					
	11-13-12 at 9:	30 a.m. until 11-15-12					
	at 1:00 a.m. in	which the "description"					
	was document	ed as "watery large."					
	Further review	of the medication					
	record indicate	ed the resident received					
	the additional	dose of MiraLax at 9:31					
		-12 and then again at					
		11-10-12, and not at					
	· ·	the additional dose of					
		ot administered to the					
		-05-12, or on 11-09-12					
	when the resid	lent had no stools.					
	0 Th	for Double of UD!					
		for Resident "B" was					
		1-14-12 at 1:10 p.m.					
	1	luded, but were not					
	1	ertension, arthritis,					
		abetes mellitus and					
		cular disease. These					
	time of the rec	nained current at the					
	unie or the rec	oru review.					
	Review of the	resident's Minimum					
		ssment, dated 04-12-12					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPL	ETED
		155704	B. WIN		<del></del>	11/15/	2012
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹		505 N N	MAIN ST		
WALDRO	ON HEALTH AND F	REHAB CENTER			RON, IN 46182		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA:	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	indicated the resident was not						
	cognitively imp	paired, and required					
	extensive assis	stance with transfer and					
	bed mobility.						
	A current plan	of care, originally dated					
	05-16-11, indic	cated the resident had					
	"self care defic	it related to weakness					
	and neuropath	y as evidenced by					
	extensive - to t	total dependent with					
	bed mobility, tr	ansfer, dressing and					
	toileting."						
	G						
	The resident h	ad recently been					
		he facility on 10-31-12,					
	after a hospital	•					
	Review of the	hospital "Discharge					
		oort, dated 10-31-12					
	·	und Care Orders - BID					
		ay] apply Xenaderm to					
		rn Q [every] 2 hrs.					
		aper pads at all at all					
		Ise waffle mattress					
		bed at all times to					
	•						
		right due to sacral area					
	_	age 2 pressure ulcer					
	'	continence associated essure relief when in					
		o, try to limit time in					
		2 hours at a time, allow					
	•	times from the					
	wheelchair."						
	During observa	ation on 11-15-12 at					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	00	COMPLE	ETED
		155704	A. BUI B. WIN			11/15/2	2012
			D. WII		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	8		505 N M			
WALDRO	N HEALTH AND R	REHAB CENTER			RON, IN 46182		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	9:00 a.m., the seated in the w	resident was in room, /heelchair.					
	5	44.45.40.40.05					
	_	w on 11-15-12 at 9:05					
		ent's spouse indicated					
		icility that morning					
		.m. and [resident] was					
	· •	Ichair when I got here.					
		plains about the sore					
		ng to the lower back -					
		n the wheelchair for					
	• .	time doesn't make it					
	any better."						
	During observa	ation at 10:25 a.m., the					
	•	ned in the wheelchair					
		was made to do a body					
	•	While waiting for the					
		bring the mechanical lift					
		s room, the resident					
		been up in this chair					
		30 a.m. My bottom					
		nterviewed if the					
		ad attempted to check					
	•	r incontinence, and a					
		•					
	•	tioning, the resident					
	indicated "No, I haven't been changed						
	or anything."						
	The Director of	Nurses and Certified					
	Nurses Aide po	ositioned the resident					
	onto the mech	anical lift and					
	transferred the	resident to bed.					
	Registered Nu	rse employee #3,					

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	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155704		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 11/15/2012
	PROVIDER OR SUPPLIED ON HEALTH AND F		505 N N	ADDRESS, CITY, STATE, ZIP CODE MAIN ST RON, IN 46182	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	care nurse, wa attendance du the resident's s After the reside	Staff, as the wound as requested to be in ring the assessment of skin.			
	was observed and the sacral	ef were removed, stool in the incontinent brief, area was bright red rea was observed.			
	This Federal to Complaints INI IN00119144.	_			
	3.1-35(g)(2)				

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155704	B. WING		11/15/2012
NAME OF F	PROVIDER OR SUPPLIER	· {		ADDRESS, CITY, STATE, ZIP CODE	
				MAIN ST	
WALDRO	ON HEALTH AND R	REHAB CENTER	WALD	RON, IN 46182	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0309	483.25	CEDVICES FOR			
SS=D	HIGHEST WELL	SERVICES FOR			
		ust receive and the facility			
		necessary care and			
		or maintain the highest			
	practicable physic				
		Il-being, in accordance with			
	care.	ve assessment and plan of			
		w and record review,	F0309	Resident A was assessed by	12/14/2012
		ed to ensure a resident	10309	nursing and found to have no	12/11/2012
		of chronic constipation		adverse effects from alleged	
	and fecal impa			deficient practice. His bowel	
		ongoing nursing		regimen was assessed and modifie	d
		bowel regime for 1 of		by his primary healthcare provider	
		riewed for chronic		2. All residents have the	
				potential to be effected by the	
	Consupation in	a sample of 5.		alleged deficient practice.	
	Findings includ	Ja.		<ol><li>Facility nursing staff have be reinserviced on bowel managemen</li></ol>	
	Findings includ	JC.		practices.	
	The recent for	Decident "A"		4. The Director of Nursing or	
		Resident "A" was		Designee will monitor Bowel	
		1-14-12 at 10:35 a.m.		Movement Reports for correct	
	_	luded, but were not		intervention twice weekly and	
		bral palsy, chronic		report results to the Quality	
	•	istory of abdominal		Assessment and Assurance	
	l <sup>-</sup>	eus, diabetes mellitus		Committee for six months.	
	•	c bladder. These			
		nained current at the			
	time of the reco	ord review.			
	Review of a "M	lajor Internal Medicine"			
	report, dated 0	6-26-12, indicated the			
	resident had a	recent assessment of			
	"Clostridium di	fficile - plan: Continue			
		ent] bowel pattern			
	carefully."	a 1 ***			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE	E CONSTRUCTION	(X3) E	DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00		OMPLETED
		155704	B. WING		1·	1/15/2012
NAME OF I	PROVIDER OR SUPPLIE	P	STRE	ET ADDRESS, CITY, STATE, ZIP	CODE	
NAME OF I	ROVIDER OR SOLITEE	N.		N MAIN ST		
WALDRO	ON HEALTH AND F	REHAB CENTER	WAL	DRON, IN 46182		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI	N SHOULD BE	COMPLETION
TAG	REGULATORY OI	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
		of the record indicated				
		ad hospitalizations for				
		ns. The hospitalization				
	dates included					
	"severe rectal	fecal impaction," a				
		on 08-06-12, with				
		nments related to a				
	_	ecal impaction," and				
	10-27-12, with	primary/secondary				
	diagnoses - fe	cal impaction, and				
	paralytic ileus.					
	Review of hos	pital "Imaging" reports				
	dated 05-30-1	2, "Indication: elevated				
	white blood ce	ell count, subjective				
	abdominal cor	nplaints - Impression:				
	severe fecal in	npaction., and 10-27-12				
	"Indication: Al	bdominal pain and				
	distention - Im	pression: Ileus with a				
	severe fecal in	npaction."				
	The resident's	current plan of care,				
	originally date	d 10-20-08 and current				
	as of 11-01-12	2, indicated "Potential				
	for constipatio	n/gastric distress - Dx.				
	[diagnoses] ch	ronic constipation,				
	cerebral palsy	health issues." The				
	"goal" to this p	lan of care included				
	"Resident will	have 2 - 4 bowel				
	movements Q	D [every day]."				
		to this plan of care				
		el sounds prn [as				
		ort loose stools, abd.				
	[abdominal] di					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		155704	B. WING	G		11/15/	2012
NAME OF B	DOMBED OF GLIDNINE			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIEF			505 N M	MAIN ST		
WALDRO	N HEALTH AND R	EHAB CENTER		WALDR	RON, IN 46182		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	-	ng] etc, Notify MD					
	[Medical Docto	r] as needed, Prune					
	juice prn, Reco	ord elimination, Monitor					
	elimination dat	a, MiraLax QD and prn,					
	Dulcolax supp.	[suppository] as					
		Rezyst [a probiotic					
	medication] as						
	Review of the '	'BM [bowel movement]					
		gust and September					
	•	the resident had no					
		ent from 08-30-12 at					
		09-04-12 at 7:55 p.m.,					
		14 a.m. through					
		the document					
		esident had a medium					
		ent at 10:18 a.m., and					
		ive another bowel					
		n the time of the					
		movement recorded					
		ntil 10-06-12 at 10:17					
	a.m., when the	resident had a "large"					
	bowel moveme	ent.					
	Paview of an "	alert report" indicated					
		12 at 4:00 p.m last					
		•					
		3 days and 6 hours ago					
		st] 30 9:40 a.m					
		solved 09-08-12 [9					
		.m. had lg [large] bm."					
		ved on 11/15/12 at					
	12:50 p.m., reg	garding what					
	interventions w	ere attempted for the					
	resident's bow	el regime, the Director					
	of Nurses indic	ated, "I don't have					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155704	B. WIN	IG		11/15/	2012
NAME OF I	PROVIDER OR SUPPLIEI	₹			ADDRESS, CITY, STATE, ZIP CODE		
WALDD(		DELLAD CENTED			MAIN ST		
WALDRO	ON HEALTH AND F			<u> </u>	RON, IN 46182		
(X4) ID		MMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL  SLSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
1710		o give you for this one;		1110			DATE
		hat was done."					
	I don't know w	nat was done.					
	A subsequent "alert report" dated 09-26-12 at 8:00 a.m., indicated "last						
		3 days ago, on Sep.					
		3 at 7:44 a.m					
	Resolution - re	solved will give PRN or					
	prune juice." [	During interview on					
		::50 p.m., the Director					
		cated "I don't know					
	_	gard to the licensed					
	nurse] gave to	the resident."					
		tes, dated 10-27-12 at					
	· ·	cated "noted resident					
		aving hiccups - resident					
	_	and crying out off and ed on: <sic> asked</sic>					
		pened during the night					
		said 'yes.' Asked if it					
		terday and [resident]					
	1 ''	nsert GT [gastrostomy					
		o let out air, large					
	, ,	vas removed. Bowel					
		active. Last BM today					
	this a.m."	<b>,</b>					
	Review of the	October 2012 BM					
		ed the resident had a					
	"small" bowel ı	movement on 10-27-12					
	at 7:51 a.m.						
		as transported to the					
	local hospital e	emergency room on					

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	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COM	TE SURVEY MPLETED
		155704	B. WING		<b>—</b> 11/	15/2012
	PROVIDER OR SUPPLIEF		505 N N	ADDRESS, CITY, STATE, ZIP C MAIN ST RON, IN 46182	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) 30 a.m.	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	Review of the indicated "[resi abdominal pair receiving call for reporting pt. [p of] diffuse abdogagging sensate describe or rate to chronic illne has history of it concerned about ED [emergence fecal impaction Disimpaction 2 fentanyl [pain restool in finger of amount felt distended by the concerned about the soap sud sick watery return. 2nd disimpactions and disimpactions of the stool. Clin Fecal impactions are the hospital In 10-27-12 indicated. "I water region in the the region in the series and the series and the the region in the series and	emergency room report ident] here with h, family reports rom Waldron Rehab. atient] c/o [complains ominal pain, with tion. Pt unable to e pain 2/2 [secondary] ss. Family reports pt leus in the past and is out possible recurrence. by department] course: h with obstruction. It is made to make the possible recurrence of the possible recurrence. It is made to make the possible recurrence. It is made to make the possible recurrence of the possible recurrence. It is made to make the possible recurrence of the possible recurrence of the possible recurrence. It is made to make the possible recurrence of the possible recurrence of the possible recurrence of the possible recurrence. The possible recurrence of the possible r				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED
		155704	B. WIN			11/15/2012
			D. WII.		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	₹			MAIN ST	
WALDRO	ON HEALTH AND F	REHAB CENTER			RON, IN 46182	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	The patient is	a [description of				
	resident] with s	severe cerebral palsy.				
	· -	is admitted because				
	[resident] could					
		T scan was performed				
		•				
	i ilai showed a	large fecal ball."				
		1. ( 1.5)				
		History and Physical"				
	· ·	0-28-12 also indicated				
	"the fecal ball i	s quite large and				
	[resident] is ha	ving difficulty passing				
	it. General sur	rgery has been				
	consulted and	_ ,				
	intervene."	,				
	intervence.					
	The beenital "	Physician Progress				
	· ·	0-30-12 indicated the				
		surgery performed				
	aggressive dis	impaction."				
	The resident w	as re-admitted to the				
	facility on 11-0					
	13.5, 5	,				
	Review of the	"Discharge Instruction				
		11-01-12, indicated				
	<u>-</u>					
	l '	s <sic> and administer</sic>				
	-	medication to aide in				
		e dose prior to the				
	initiation of tub	e feeds each night."				
	"Additional Ord	ders/Comments"				
	included "Ideal	lly [resident] will have 2				
		lay. If [resident] misses				
		ut a stool then give 2				
	1 .	_				
		ax that day. If the				
	Tollowing day [	resident] has no stool,	$\perp$			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155704	B. WIN			11/15/	2012
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R		505 N N	MAIN ST		
WALDRO	ON HEALTH AND F	REHAB CENTER			RON, IN 46182		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5)
PREFIX	``	NCY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG			DATE
	notify physicia	n."					
	Review of the						
	administration	record for November					
	2012 indicated	I the physician order					
	dated 11-01-12	2 for MiraLax 255 gm					
		[ounces] give 17 gram					
	,	trostomy feeding tube]					
	'	of water prn a day					
		nen give a dose of					
		0 a.m. Resident goal is					
	2 - 4 soft stools	<u> </u>					
	2 - 4 5011 51001	s per day.					
	Review of the	"RM [howel					
		eport for the resident					
	_	•					
		of re-admission					
		esident had one bowel					
		11-04-12, 11-06-12,					
	· ·	9-12, 11-11-12, and					
	11-13-12, and						
	movements or	11-05-12 from 4:13					
	a.m. thru 11-06	6-12 at 8:00 p.m. when					
	the document	indicated the resident					
	had a large bo	wel movement, no					
	bowel moveme	ent from 11-09-12 at					
	10:33 a.m., un	til 11-11-12 at 4:30					
	· ·	owel movement from					
		30 a.m. until 11-15-12					
		which the "description"					
		ed as "watery large."					
	was document	.cu as watery large.					
	Further review	of the medication					
		ed the resident received					
		dose of MiraLax at 9:31					
	a.m., on 11-02	-12 and then again at					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155704		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION  00	COM	E SURVEY PLETED 5/2012	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CO MAIN ST ON, IN 46182	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
	6:00 a.m., but the MiraLax was not resident on 11-when the resident of the f	11-10-12, and not at the additional dose of ot administered to the 05-12, or on 11-09-12 ent had no stools.  Tacility "Bowel gulation," policy on					
	11-15-12 at 12 following:	:30 p.m., indicated the					
	* Nursing to do	o help prevent fecal impaction. ocument occurrence vel movement daily.					
	* Licensed nur documentation						
		is had no of bowel movement nen prune juice will be					
		s no documentation then laxative will be					
	This Federal ta IN00119082.	g relates to Complaint					
	3.1-37(a)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155704		(X2) MULTIPLE C  A. BUILDING	ONSTRUCTION  00	(X3) DATE SURVEY  COMPLETED	
		155704	B. WING		11/15/2012
	ROVIDER OR SUPPLIER		505 N	ADDRESS, CITY, STATE, ZIP CODE MAIN ST RON, IN 46182	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
F0314 SS=D	PRESSURE SOF Based on the cona resident, the fact resident who enter pressure sores do sores unless the condition demons unavoidable; and sores receives ne services to promotin infection and previous developing. Based on observe ord review, ensure a dependent reatment and shealing and predeveloping by repositioning a for 1 of 3 reside pressure ulcers [Resident "B"]  Findings include The record for reviewed on 11 Diagnoses including peripheral vasodiagnoses remained of the record for reviewed on 11 diagnoses remained of the record for reviewed on 11 diagnoses including peripheral vasodiagnoses remained of the record for record for reviewed on 11 diagnoses including peripheral vasodiagnoses remained of the record for reviewed on 11 diagnoses remained to hyperipheral vasodiagnoses remained the record for reviewed on 11 diagnoses remained the record for reviewed on 11 diagnoses including peripheral vasodiagnoses remained the record for reviewed on 11 diagnoses including peripheral vasodiagnoses remained the record for reviewed on 11 diagnoses remained the record for reviewed on 12 diagnoses remained the record for reviewed on 12 diagnoses remained th	Inprehensive assessment of cility must ensure that a sers the facility without been not develop pressure individual's clinical strates that they were a resident having pressure ecessary treatment and ote healing, prevent vent new sores from a revation, interview and the facility failed to indent resident received services to promote event new sores from implementing and incontinent needs, ents reviewed for a in a sample of 5.  Resident "B" was 1-14-12 at 1:10 p.m. uded but were not rension, arthritis, betes mellitus and cular disease. These ained current at the	F0314	1. Resident B was assessed nursing and found to have no adverse effects from alleged deficient practice. Resident B continues to have incontinent dermatitis from stool leakage His repositioning schedule habeen reviewed and revised to schedule of his agreement. 2. residents have the potential the effected by the alleged deficing practice. 3. Facility nursing strinserviced on reposition schedules and incontinent cattiming. 4. The Interdisciplinate Team will match CNA worksheets, Care Plans and resident position during Interdisciplinary Team Rounce ensure that each resident is positioned and repositioned according to his or her care part of the IDT will report results to Quality Assessment and Assurance Committee for ongoing review and recommendations for six more	Basical All obe ent aff arry disto

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITE	LDDIC	00	COMPL	ETED
		155704	A. BUI. B. WIN	LDING		11/15/	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹					
WALDD.		DELIAD CENTED		1	MAIN ST		
WALDRO	ON HEALTH AND F	REHAB CENTER		WALDR	RON, IN 46182		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Data Set asses	ssment, dated 04-12-12					
	indicated the re	esident was not					
	cognitively impaired, required extensive assistance with transfer,						
		ygiene, toileting and					
		incontinent of bowel					
	and bladder.						
	· ·	of care, originally dated					
	· ·	cated the resident had					
	"self care defic	it related to weakness					
	and neuropath	y as evidenced by					
	extensive - to t	total dependent with					
		ansfer, dressing and					
	toileting."	anoron, anocoming and					
	tolicting.						
	A aubaaauaat	aumant plan of save					
	•	current plan of care,					
		d 05-16-11, indicated					
		ad the "potential for					
	impaired skin i	ntegrity related to					
	"requires assis	tance with turning and					
	repositionina. i	mpaired mobility, and					
		powels [wears briefs]."					
		o this plan of care					
		•					
	-	sure reducing mattress					
	• •	re reducing cushion to					
	-	ir], Xenaderm ointment					
	as ordered."						
	The resident h	ad recently been					
	readmitted to t	he facility on 10-31-12,					
	after a hospital	-					
	S						
	Review of the	hospital "Discharge					
	i instruction Ref	oort" dated 10-31-12,	- 1				1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155704	B. WIN	G		11/15/2012
NAME OF P	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
					MAIN ST	
WALDRO	ON HEALTH AND R	EHAB CENTER		WALDR	ON, IN 46182	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE
		und Care Orders - BID				
	_	y] apply Xenaderm to				
		n Q [every] 2 hrs.				
		per pads at all at all				
		se waffle mattress				
	•	bed at all times to				
		ight due to sacral area				
		age 2 pressure ulcer				
	-	continence associated essure relief when in				
		o, try to limit time in				
		? hours at a time, allow				
	pressure relief	•				
	wheelchair."	unes nom the				
	wriceichair.					
	During observa	ation on 11-15-12 at				
	_	resident was in room,				
	seated in the w	-				
	Durina intervie	w on 11-15-12 at 9:05				
		ent's spouse indicated				
		cility that morning				
		.m. and [resident] was				
		Ichair when I got here.				
	l •	plains about the sore				
		g to the lower back -				
		n the wheelchair for				
		time doesn't make it				
	any better."					
	During observa	ation at 10:25 a.m., the				
	_	ned in the wheelchair				
		was made to do a body				
		While waiting for the				
		oring the mechanical lift				

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	<u>'</u>			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING		00	COMPLETED	
		155704	B. WIN	G		11/15/2012	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
WALDRON HEALTH AND REHAB CENTER			505 N MAIN ST WALDRON, IN 46182				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		COMPLETION	
TAG				TAG	DEFICIENCY)	DATE	
	to the resident's room, the resident indicated "I've been up in this chair since about 6:30 [a.m.] this morning, my bottom hurts." When interviewed if the nursing staff had attempted to check the resident for incontinence, and a change in positioning, the resident indicated "No, I haven't been changed or anything."						
	changed or an	ytillig.					
	During this observation, the resident placed right had on the hand rest of the wheelchair, pushing self in an upward direction. When interviewed if [resident] sacral area was sore, the resident indicated "yes."						
	The Certified Nurses Aide brought the mechanical lift into the resident's room, and the Director of Nurses and Certified Nurses Aide positioned the resident onto the mechanical lift and						
	transferred the	resident to bed.					
		rse employee #3,					
	identified on th	•					
		Staff, as the wound as requested to be in					
		ring the assessment of					
	the resident's	•					
		ent's slacks and					
	incontinent brief were removed, stool was observed in the incontinent brief,						
	and along the	edges of the reddened					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					· ′	X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED			
155704			B. WING			11/15/	11/15/2012	
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF FROVIDER OR SUFFLIER					MAIN ST			
WALDRON HEALTH AND REHAB CENTER			WALDRON, IN 46182					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION	
TAG				TAG	DEFICIENCY)		DATE	
	area of the sacrum. The resident's							
	sacral area was bright red in appearance and an open area was							
	also observed.							
	The measurements of the reddened							
		the wound care nurse						
		meters in width by 9.0						
	centimeters in length," with an additional reddened area in the fold of the right buttocks, which measured "5.0 centimeters by 4.0 centimeters," and a small open area located on the							
	right upper section of the reddened area and described by the wound care nurse as a "slit" which measured ".5 centimeters by .1 centimeters."  During this observation the wound care nurse indicated the resident had "constant stool," and "that is what caused the irritation [redness] to the dermatitis." The wound care nurse							
	further indicate							
		eddened area as						
		[resident] did not have						
	a pressure ulce	-						
	•							
	During intervie	w on 11-15-12 at 1:35						
	p.m., the hospi							
	•	the wound nurse and						
	the Director of	Nurses, and the wound						
		d she was unaware the						
resident had a pressure ulcer while in								
	the hospital.							

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/10/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:  155704	(X2) MULTIPLE CC  A. BUILDING  B. WING	00	11/15	LETED 5/2012		
NAME OF PROVIDER OR SUPPLIER  WALDRON HEALTH AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 505 N MAIN ST WALDRON, IN 46182					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES SICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE		
	IN00119144.	ag relates to Complaint						
	3.1-40(a)(2)							

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Event ID: EP5G11

Facility ID: 000423

If continuation sheet

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